AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING IN WING STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH STREET EVANSVILLE, IN47713 SITEMATIVE THAT STREET EVANSVILLE, IN47713 ID ROUDUST PRAY OF CORRECTION SUMMARY STATEMENT OF DEPRCIENCIES PREFEX GRACH DEPCINITY MIST BE PERCEDED BY FULL TAG TAG ROUDUST PRAY OF CORRECTION STATEMENT OF A STATEMENT OF DEPCINITY OF THE PREFEX STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH STREET EVANSVILLE, IN47713 ID ROUDUST PRAY OF CORRECTION SOMPLETION OF THE PROPRIET COMPLETION DATE ROUDUST PRAY OF CORRECTION SOMPLETION All residents have the potential to be affected. All residents have the potential to be affected. All residents have the potential to be affected. Survey dates: August 29, 30, 31, September 1, 2011 Facility number: 011274 AIM number: N/A Survey team: Diane Hancock, RN TC Amy Wininger, RN Census bed type: Residential: 77 Total: 77 Census payor type: Other: 77 Total: 77 Sample: 7 Supplemental sample: 5 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed 9/2/11 by Jennie Bartelt, RN.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	1			X3) DATE SURVEY		
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		in accordance wi	ui 410 IAC 10.2.						
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John C Dartett, Kiv.			-						
i i i i i i i i i i i i i i i i i i i		Jennie Darteit, Kl	LY.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

6C2E11

Facility ID:

011274

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **401 SE SIXTH STREET** RIVERWALK COMMUNITIES LLC **EVANSVILLE, IN47713** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (j) The facility shall observe safety precautions R0153 when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. All resident have the potential to Based on observation, interview, and R0153 10/01/2011 be affected. The oxygen that is in record review, the facility failed to ensure the facility is now tethered in the safety of stored oxygen cylinders, in compatible metal cylinder holders that 3 oxygen cylinders were observed as per supplier's untethered in 1 of 1 oxygen storage area. recommendation. The supplier's delivery personal, nursing staff This had the potential to affect 77 and maintenance personal have residents currently residing in the facility. been in-serviced on proper storage of oxygen cylinders. An audit will be done by the director Finding includes: of nursing or his designee. This will be done weekly times four, In an interview on 08/31/11 at 2:20 P.M., monthly times 4 and quarterly LPN #1 indicated that full oxygen tanks times four to assure that oxygen tanks remain secured. Results of were stored in the employee breakroom. the audit will be forwarded to QA. In addition a sign will be posted During the environmental tour, on as a reminder. The sign will read 08/31/11 at 2:30 P.M., the oxygen storage "Oxygen must be in proper metal housing and secured at all times". area was observed to be located in the Exhibit A In-serviceExhibit B employee breakroom. Three oxygen Posted SignExhibit C Audit Form cylinders were observed to be freestanding and unsecured in the corner of the employee breakroom. At that time, Maintenance Assistant #1 indicated the oxygen tanks had always been stored in the breakroom and the tanks did not need to be secured. The Policy and Procedure for Liquid Oxygen Use, provided by the DoN [Director of Nursing] on 08/31/11 at 3:30 P.M. indicated, "...House supply of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING OO OO OO OO OO OO OO OO OO					
			B. WING		09/01/2011		
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH STREET EVANSVILLE, IN47713				
(X4) ID PREFIX TAG	ceach deficien regulatory or oxygen will be stored the MSDS [Mat for oxygen from provided by the I A.M. The MSDSStorageCylin	tatement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Tored in a vented room." erial Safety Data Sheet] the oxygen vendor was DoN on 09/01/11 at 10:25 indicated, "Section 7. ders should be stored o prevent falling or being	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
R0246	a qualified medical authorization by a The QMA must require authorization for emedication. All complysician not on the authorization to accommend in the time and date Based on observed record review, the that a QMA [Quareceived authorization authorizatio	ach administration of a PRN intacts with a nurse or the premises for Iminister PRNs shall be a nursing notes indicating of the contact. action, interview, and the facility failed to ensure allified Medication Aide] that in from a licensed aninistering medications to the sidents [Residents #36,	R0246	All residents have the potent be affected. The nursing state Nurses and Qualified Medicates (QMA), has been in-serviced on the proper procedure of the QMA's administering PRN medication. The DON or his designee will audit 10 percent of the Medicates Administration Records (MAI PRN medications administer QMA. This will be done daily times 2 weeks, once weekly times four weeks, once mont times four months and then controlled the controlled	ons. Il cation R) for ed by y thly once		

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Event ID: 6C2E11 Facility ID: 011274

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STATEMENT OF DEFICIENCIES (X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
			B. WING 09/01/2011			011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			SIXTH STREET		
DI\/ED\/	ALK COMMUNITIE	SIIC		1	VILLE, IN47713		
	ALK COMMONTIE	3 LLC		L	VILLE, IN477 13		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)	DATE	
	the authorization	of a nurse.			review these audits as well.	The	
					results of the audits will be		
	Findings include	:			forwarded to QA. Exhibit D In-service on PRN medication	'n	
					AdministrationExhibit E Audi		
	1 On 08/30/11	at 2:00 P.M., Resident			Form for PRN Medications	`	
		ed to approach QMA #1 at					
		n and request cough					
	1	was observed to					
	administer the co	ough syrup without					
	receiving author	ization of a nurse.					
	The MAR [Med	ication Administration					
		dent #36 was reviewed on					
	_	0 A.M. The MAR					
		ent #36 had received					
		5 cc prn [as needed]					
		The Nurse's medication					
	note lacked any	documentation that the					
	administration o	f Guaifenesin was					
	authorized by a	nurse.					
	2 The clinical r	ecord of Resident #5 was					
		30/11 at 11:45 A.M. The					
	1 1	cian's Order recap, signed					
	7/15/11, indicated Resident #5 was to receive Lortab 5 mg [milligram] [a narcotic pain medication] every four						
	hours as needed.						
	The August 201	MAR [Medication					
	1	Record] of Resident #5					
		1 08/31/11 at 10:00 A.M.					
		nted Resident #5 was					
	administered Lo	rtab five times prn [as					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION 00	(X3) DATE		
THISTERN			A. BUIL			09/01/2	
<u> </u>			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					SIXTH STREET		
RIVERWALK COMMUNITIES LLC					VILLE, IN47713		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		A #1 [08/2/11, 08/4/11,					
	08/9/11, 08/11/11						
		ication notes lacked any					
		nat the administration of					
	Lortab had been	authorized by a nurse.					
	3. The August 20	011 MAR of Resident					
	_	d on 08/31/11 at 10:00					
	A.M. The MAR	indicated the Resident					
	#11 had received	Lortab 7.5 mg					
	[milligram] prn e	eight times from QMA #1					
	[twice on 08/04/]	11, 08/05/11, 08/11/11					
	and once on 08/0	08/11 and 08/09/11]. The					
	MAR further ind	icated Resident #11 had					
	received Ativan	1 mg [anti-anxiety] prn					
	three times from	QMA #1 [08/04/11,					
	08/05/11, 08/11/	•					
	medication notes	•					
		nat the administration of					
	Ativan had been	authorized by a nurse.					
	4 The August 20	011 MAR of Resident #8					
		08/31/11 at 10:00 A.M.					
		ted the Resident #8					
		yl 25 mg. [for allergic					
	reactions] once [
	Oxycodone [narcotic pain medication] 5/325 mg twice [08/04/11 and 08/15/11] from QMA #1. The Nurse's medication notes lacked any documentation the						
	administration of						
		been authorized by a					
	nurse.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING O			COMPLETED 09/01/2011	
			B. WIN			09/01/2	U11
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
RIVERWALK COMMUNITIES LLC				1	SIXTH STREET VILLE, IN47713		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	ı	2011 MAR of Resident #1					
		n 08/31/11 at 10:00 A.M.					
		ated that Resident #1					
		yl 25 mg prn six times					
	l -	/11, 08/11/11, 08/15/11,					
	· ·	[11] from QMA #1. The					
		licated Resident #1					
		m 4 mg [anti-diarrhea					
	_	e [08/15/11] from QMA					
		medication notes lacked					
	any documentation that the administration						
	of Benadryl and	Imodium had been					
	authorized by a	nurse.					
	1	2011 MAR's of Resident					
		red on 08/31/11 at 10:00					
		indicated the Resident					
		van 1 mg prn once					
	1	QMA #1. The Nurses					
	medication notes	•					
		hat the administration of					
	Ativan had been	authorized by a nurse.					
	7. The policy ar	•					
	medication administration was provided						
	by the DoN on 0	08/31/11 at 3:00 P.M.,					
	"5. QMA's will inform the licensed nurse when a resident is in need of a PRN						
	medication. The licensed nurse will sign						
	off on the PRN medication with the QMA"						
	Q In an intervie	w with the DoN on					
		w with the DoN, on					
	U8/31/11 at 12:4	5 P.M., he indicated,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/01/2011			
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH STREET EVANSVILLE, IN47713				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	-	d tell the nurse, the sess and initial with the					
R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident 's clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to ensure the disposition of medications for 2 of 2 sampled residents who were discharged from the facility, in the sample of 7, was documented in the residents' records. (Residents #78, #79)		R0306	All residents have the potent be affected. The nursing sta Nurses and QMA's have bee in-serviced on the proper procedure of documenting medication disposition of discharged residents. Two nursing personal will sig on the medication disposition form to assure procedures a followed correctly.	uff, en gn off n		
	reviewed on 8/31	s clinical record was /11 at 10:30 a.m. The resident, dated 12/14/10,		Upon discharge each reside will be audited by the DON of designee to assure proper			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LDING	00	COMPI	LETED	
			B. WING 09/01/2011					
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, ZIP CODE			
DIVEDWALK COMMUNITIES LLC			401 SE SIXTH STREET EVANSVILLE, IN47713					
	RIVERWALK COMMUNITIES LLC			<u> </u>	VILLE, IN477 13			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		p	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	indicated the fac	ility administered the			disposition of medications a	nd		
	resident's medica	ations. The resident had			proper documentation is in	roina		
	been discharged	from the facility on			resident file. An outside nu consultant will review these	-		
	8/9/11, to anothe	er facility. The record			as well. The results of the a			
		documentation of the			will be forwarded to QA.			
	disposition of he	er medications.			Exhibit F In-service for prop medication disposition and	er		
					documentation			
		's clinical record was			Exhibit G Audit form for			
	reviewed on 9/1/11 at 9:30 a.m. The resident had a physician's order, dated 7/18/11, indicating, "May discharge to [name of apartment complex] with meds				discharged residents			
	_ ^	There were discharge						
		uding a medication list,						
		accounting for the						
		abers, the number of						
	1 ^	I the disposition of the						
		what exactly was sent						
	with the resident	-						
		h the Director of Nurses,						
		55 a.m., indicated the						
		contain disposition of						
	medications upo	n discharge.						

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